CHECKLIST FOR THE INITIAL APPROVAL OF AN INSURED PREFERRED PROVIDER PLAN
Pursuant to the Requirements of M.G.L. c. 176I and 211 CMR 51.00
(When submitting an initial application for an Insured Preferred Provider Plan, please also submit the appropriate Managed Care Checklists.)

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:
Pursuant to Bulletin No. 2001-05, please ***include a completed checklist when submitting an application for an insured preferred provider plan.***

When completing this checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.

- ***For items requiring company confirmation, please place a checkmark (√) next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable (N/A), please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.***
- ***For carriers filing stand-alone dental or vision insured preferred provider plans, please review Chapter 162 of the Acts of 2005.***

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____

Product Name & Form #:
(Please attach a separate sheet if necessary to identify all forms submitted with the filing.) _____

_____

$100 filing fee remitted pursuant to 801 CMR 4.02(28): _____

FILINGS THAT DO NOT INCLUDE ALL APPLICABLE FULLY COMPLETED CHECKLISTS WILL BE RETURNED AND NOT REVIEWED. PLEASE REVIEW THE FOLLOWING ADDITIONAL CHECKLISTS TO ASSURE YOUR SUBMISSION IS COMPLETE:
Managed Care: Health Maintenance Organizations
Managed Care: Insurance Companies
Managed Care: Provider Contracts

Carrier Certification:

I _____ a duly authorized representative of _____ certify that it is my good faith belief based on the review of this checklist and submitted materials that the submitted materials comply with applicable Massachusetts law.

FOR DIVISION OF INSURANCE USE ONLY:

Date Received: _____

Reviewed by: _____

The following organizations may currently operate insured preferred provider plans according to the provisions of M.G.L. c. 176I and 211 CMR 51.00:

- Companies licensed to write health insurance pursuant to M.G.L. c. 175;
- Fraternal Benefit Societies licensed to write health insurance pursuant to M.G.L. c. 176;
- Non-Profit Hospital Service Corporations organized under M.G.L. c. 176A;
- Medical Service Corporations organized under M.G.L. c. 176B;
- Dental Service Corporations organized under M.G.L. c. 176E;
- Optometric Service Corporations organized under M.G.L. c. 176F; and
- Health Maintenance Organizations licensed to write health insurance pursuant to M.G.L. 176G.

211 CMR 51.03: Applicability

No Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be offered without meeting the filing and other requirements set forth in M.G.L. c. 152 and 176I, and until it is approved by the Commissioner in accordance with the provisions of 211 CMR 51.00.

Definitions from M.G.L. c. 176I, § 1 and 211 CMR 51.02:

_____ Emergency Care, "services provided in or by a hospital emergency facility to a Covered Person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the Covered Person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

_____ Emergency Medical Condition, "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the covered person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

_____ Preferred Provider, "a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement."

_____ Preferred Provider Arrangement, "a contract between or on behalf of an Organization and a Preferred Provider that complies with all the applicable requirements of M.G.L. c. 152 c. § 30, c. 176I, and 211 CMR 51.00."

_____ Preferred Provider Health Plan, "an insured Health Benefit Plan offered by an Organization that provides incentives for Covered Persons to receive Health Care Services from Preferred Providers in the context of a Preferred Provider Arrangement. A Workers' Compensation Preferred Provider Arrangement shall not be considered a Preferred Provider Health Plan under this regulation."

_____ Usual and Customary Charge, "the fees identified by a carrier as the usual fees charged by similar Health Care Providers in the same geographic area."

_____ Workers' Compensation Preferred Provider Arrangement, "a Preferred Provider Arrangement between an insurer, self-insurer, or self-insurance group, as defined in M.G.L. c. 152, §§ 1, 25A, or 25E, respectively, and a Preferred Provider to provide all or a specified portion of Health Care Services resulting from workers' compensation claims by Covered Persons against such insurer, self-insurer or self-insurance group under the provisions of M.G.L. c. 152, §30."

Approval of Preferred Provider Health Plans and Workers Compensation Preferred Provider Arrangements - 211 CMR 51.04(1):

According to 211 CMR 51.04(1), "[n]o Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be approved without first submitting an application in a format specified by the Commissioner that includes at least the following:

_____ (a) A description of the geographical area in which the Preferred Providers are located, including a map of the distribution of the Preferred Providers;

_____ (b) A description of the manner in which covered Health Care Services and other benefits may be obtained by persons using the Preferred Providers, including a description of the grievance system available to Covered Persons, including procedures for the registration and resolution of grievance and any requirement within a Preferred Provider Health Plan that Covered Persons select a gatekeeper provider;

_____ (c) Provider contracts and contracting criteria, including:

1. A narrative description of the financial arrangements between the Organization and contracting Health Care Providers, identifying any assumption by the providers of financial risk through arrangements such as per diems, diagnosis-related groups, capitation or percentage withholding of fees;
2. A copy of every standard form contract with preferred physicians and other Health Care Providers, including providers joining the Preferred Provider Arrangement via leasing, subcontracting, or other arrangements whereby the Organization does not contract directly with the providers (do not include rates of payment to providers);
3. A copy of every standard form contract for all Preferred Provider Arrangements including administrative service agreements;
4. A copy of the terms and conditions that must be met or agreed to by health care providers desiring to enter into the Preferred Provider Arrangement(s) (do not include rates of payments to health care providers); and
5. A description of the criteria and method used to select Preferred Providers.

_____ (d) A detailed description of the utilization review program;

_____ (e) A detailed description of the quality assurance program;

_____ (f) Preferred provider directory, which shall include:

1. A copy of the Preferred Provider directory distributed to Covered Persons; and
2. A description of the process for distributing the directory to Covered Persons.

_____ (g) Filing fee for initial applications as determined by the Executive Office for Administration and Finance as set forth in 801 CMR 4.02.

(h) Evidence of compliance with M.G.L. c. 176O and 211 CMR 52.00.
(Refer to appropriate Managed Care Checklists if applicable)

Application materials to be submitted by Preferred Provider Health Plans only – 211 CMR 51.04(2):

_____ (a) A narrative description of the Preferred Provider Health Plan to be offered, including a description of whether the plan will be available to small employers eligible under M.G.L. c. 176J;

(b) Benefits and Services.

_____ 1. A copy of every standard form contract between the Organization and Health Care Purchasers for the Preferred Provider Health Plan;

_____ 2. A copy of every standard form Evidence of Coverage for every Preferred Provider Health Plan;

_____ 3. A description of any provision for Covered Services to be payable at the preferred level until an adequate network has been established for a particular service or provider type;

_____ 4. A description of all mandated benefits and provider types available at the preferred and non-preferred level;

_____ 5. A description of the incentives for Covered Persons to use the services of Preferred Providers;

_____ 6. A description of any provisions that allow Covered Persons to obtain covered Health Care Services from a non-preferred provider at the Benefit Level for the same covered health care service rendered by a Preferred Provider; and

_____ 7. A description of any provisions within the Preferred Provider Health Plan for holding Covered Persons financially harmless for payment denials by, or on behalf of, the Organization for improper utilization of covered Health Care Services caused by Preferred Providers.

(c) Financial Resources.

_____ 1. A description of the arrangements to be used by the Organization to protect covered members from financial liability in the event of financial impairment or insolvency of any Preferred Provider that assumes financial risk; and

_____ 2. Evidence of a surety bond, reinsurance, or other financial resources adequate to guarantee that the Organization's obligations to Covered Persons will be performed.

(d) Rates.

_____ 1. A description of the Organization's methodology for establishing premium rates; and

_____ 2. A copy of the average rates for community-rated accounts, non-credible

accounts, or their equivalent in the rating structure used by the Organization.

Application Materials to be Submitted by Workers' Compensation Preferred Provider Arrangements Only - 211 CMR 51.04(3):

_____ (a) a list of each type of Health Care Provider and medical specialty involved in the proposed Preferred Provider Arrangement and the number of individuals representing each such type of practice and specialty;

_____ (b) a list of each Organization with which the Health Care Provider has previously entered into a Preferred Provider Arrangement, and of each Organization with which the applicant has a pending application for a Preferred Provider Arrangement;

_____ (c) copy of the letter from the Department of Industrial Accidents approving the applicant's arrangement's utilization review and quality assessment program;

_____ (d) a written agreement to abide by, and a description of the procedure to incorporate, any treatment guidelines or protocols promulgated by the Department of Industrial Accidents pursuant to M.G.L. c. 152, §§ 13 and 30;

_____ (e) a procedure to guarantee cooperation by Preferred Providers with the utilization review and quality assurance program which allow for the removal of noncomplying providers from the arrangement;

_____ (f) a procedure for referring Covered Persons to Health Care Services outside the Preferred Provider Plan when indicated by diagnosis, excessive travel time, and presence of any pre-existing medical condition which would make treatment substantially more difficult;

_____ (g) a position statement indicating how the applicant intends to facilitate the return to work of injured employees in a rapid, cost-effective and safe manner;

_____ (h) a copy from the Organization, if a self-insurer or self-insurance group, of the Organization's current authorization to act as a self-insurer or self-insurance group; and

(i) a copy of the information distributed annually to employees which shall include clear reference to the following:

_____ 1. that an employee is required to obtain treatment within the Preferred Provider Health Plan for the first scheduled appointment or incur the responsibility to pay for such appointment, provided that such person may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement for the initial scheduled appointment without incurring any financial obligation when such appointment is

with a licensed or registered Health Care Provider of a type or specialty not represented within the Preferred Provider Arrangement;

_____ 2. that an employee may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement after the initial scheduled appointment without incurring any obligation to pay for such subsequent visit(s) according to the provisions of M.G.L. c. 152, § 30;

_____ 3. that no copayments or deductibles may be charged employees with compensable injuries who utilize the Preferred Provider Arrangement or any other Health Care Provider under the provisions of M.G.L. c. 152 §§ 13 and 30;

_____ 4. that each Covered Person has the right to file complaints regarding the provision of Health Care Services with the Health Care Services Board within the Division of Industrial Accidents;

_____ 5. the names of all current Preferred Providers within the geographic region of such Covered Person or of all current Preferred Providers arranged geographically, to be distributed to Covered Persons upon initial approval of the Preferred Provider Arrangement; which shall also be posted in a convenient and prominent place in workplaces where covered workers are employed, and be re-distributed to Covered Persons after any alleged workplace injury or upon request; and

_____ 6. a clear description of all other rights of Covered Persons and the obligations of applicants as well as information regarding any restrictions or requirements imposed upon Covered Persons by the Preferred Provider Arrangement's utilization review or quality assurance programs.

Evidence of Coverage for Insured Preferred Provider Health Plan Coverage as outlined in 211 CMR 51.05:

_____ According to 211 CMR 51.05(1), "[t]he evidence of coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00, 211 CMR 52.00."
(Refer to appropriate Managed Care Checklist)

According to 211 CMR 51.05(2) "[t]he Evidence of Coverage must also include the following in clear and understandable language:

_____ (a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;

_____ (b) Provisions that if a Covered Person receives Emergency Care and cannot reasonably reach a Preferred Provider, payment for such care will be made at the same level and in the same manner as if the Covered Person had been treated by a Preferred Provider;

_____ (c) Benefit levels for covered Health Care Services rendered by non-preferred providers must be at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred Providers.

_____ 1. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers.

_____ 2. The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.

_____ (d) A description of all benefits required to be provided by law in accordance with all of the provisions of the Organization's enabling or licensing statutes."

Please indicate <u>for each evidence of coverage</u> the page number(s), and/or section(s), where the required information may be found.

<u>Reporting Requirements as outlined in 211 CMR 51.06:</u>

_____ According to 211 CMR 51.06(1), "[e]ach Organization with a Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to an Evidence of Coverage and significant changes to the lists of Preferred Providers."

Please confirm that the carrier will comply with this requirement.

_____ According to 211 CMR 51.06(2), "[e]ach Organization with a Preferred Provider Health Plan or a Workers' Compensation Preferred Provider Arrangement shall on April 30th of each year file with the Commissioner a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner:

(a) A summary of the number of Covered Persons;
(b) A summary of the utilization experience of Covered Persons; and
(c) A current provider directory that lists Preferred Providers by specialty and geographic area."

Please confirm that the carrier will comply with this requirement.

_____ **<u>Additional Reports</u>**

According to 211 CMR 51.06(3), "[t]he Commissioner may require an Organization to submit additional reports other than those specifically required by M.G.L. c. 176I."

Please confirm that the carrier will comply with this requirement.

_____ Carrier is subject to an assessment by the Department of Revenue as outlined in M.G.L. 176I §11. Please identify the name, title, mailing address and telephone number of the company representative responsible for filing the annual report specified in 211 CMR 51.06(2).

Name & Title: _____
E-mail address: _____
Office Address: _____
Telephone: _____
Facsimile: _____

Approval of Application

According to 211 CMR 51.04(5), "[e]ach Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement, approved under M.G.L. c. 176I and 211 CMR 51.00, may continue to be marketed unless such approval is subsequently revoked by the Commissioner. Following approval of any Workers' Compensation Preferred Provider Arrangement, a copy of the approved application must then be forwarded to the Office of Health Policy at the Department of Industrial Accidents, 600 Washington Street, Boston, MA 02111."

Please confirm that the filer understands this requirement.

Prompt Payment M.G.L. c. 176I §2:

No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud.

Please highlight this provision in all provider contracts.

SMALL GROUP PRODUCTS [M.G.L. c. 176J and regulation 211 CMR 66.00]

According to M.G.L. c. 176J §1, the term "Health benefit plan" is defined as "[a]ny individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter one hundred and seventy-five; a group hospital service plan issued by a non-profit hospital service corporation under chapter one hundred and seventy-six A; a group medical service plan issued by a non-profit hospital service corporation under chapter one hundred and seventy-six B; a group health maintenance contract issued by a health maintenance organization under chapter one hundred and seventy-six G; an insured group health benefit plan that includes a preferred provider arrangement under chapter one hundred and seventy-six I; and any multiple employer welfare arrangement (MEWA) required to be licensed under chapter one hundred and seventy-five; offered to an eligible small business.

The term "health benefit plan" shall not include accident only, credit, dental or disability income insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which beneficiaries are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-

insurance, long-term care only insurance, or any group blanket or general policy which provides supplemental coverage to medicare or other governmental programs."

Please confirm whether the filed plan is intended to be offered to groups with between one and fifty eligible employees.
YES ___ NO____
If NO, please provide the legal basis why the filed plan is not subject to the above-noted statute and regulation.

_____
__
_____
__
_____
__
_____
__
_____
__

If YES, please review Massachusetts small group law M.G.L. c. 176J and regulation 211 CMR 66.00 including guaranteed issue and guaranteed renewal requirements. Please review that law and included those provisions as required.

_____ There must be a provision for continuation of coverage for any individual, general, blanket or group policy of health, accident and sickness insurance ***(excludes supplements to Medicare or other governmental programs)*** if sold to an eligible small business or group with between 2-19 employees and the provisions for continuation of coverage should be in compliance with M.G.L. c. 176J §9. **[See also Bulletin Nos. 97-05, 96-14, and 96-12]**

CONTINUATION OF COVERAGE PROVSIONS

According to 211 CMR 52.13(1)(r), evidences of coverage shall contain a clear, concise and complete statement of the requirements for continuation of coverage mandated by state and federal law as follows:

_____ **Insured Leaves Group.** According to M.G.L. c. 175, § 110D, there is a 31-day eligibility for continued coverage in the event that an insured person leaves the group covered by such insurance unless, during such period, he shall otherwise be entitled to similar benefits.
[This provision applies only to commercial insurers.]

_____ **Plant Closing.** According to M.G.L. c. 175, § 110D, there is a 90-day eligibility for continued coverage in the event of a plant closing or partial plant closing.
[See also M.G.L. c. 176A §8D and M.G.L. c. 176B §6A]

_____ **Involuntary Layoff or Death**. According to M.G.L. c. 175, § 110G, there is a thirty-nine week eligibility for continued coverage when a member becomes ineligible for continued participation in a group plan because of involuntary layoff or death. Coverage will continue from the date of such ineligibility or until such member, his spouse and dependents become

eligible for benefits under another group plan, whichever occurs first, but in no event shall such continuation period exceed the period during which the member was most recently covered under such group plan. (See also M.G.L. c. 176A, § 8D and c. 176B, § 6A)
[**This provision applies to commercial insurers and BCBS, but not HMOs. Does not apply to dental. M.G.L. c. 175, § 110G refers to "group hospital, surgical, or medical insurance". Whereas, M.G.L. c. 175, § 110D states "Every policy of insurance" under chapter 110.]**

_____ **Divorce or Separation**: [M.G.L. c. 175, § 110I(a)-(b)]
"(a) [i]n the event of the granting of a judgment absolute of divorce or of separate support to which a member of a group hospital, surgical, medical, or dental insurance plan provided for in section one hundred and ten [of the Massachusetts General Laws] is a party, the person who was the spouse of said member prior to the issuance of such judgment shall be and remain eligible for benefits under said plan, whether or not said judgment was entered prior to the effective date of said plan, without additional premium or examination therefor, as if said judgment had not been entered; provided, however, that such eligibility shall not be required if said judgment so provides. Such eligibility shall continue through the member's participation in the plan until the remarriage of either the member or such spouse, or until such time as provided by said judgment, whichever is earlier. The provision of this section shall apply to any policy issued or renewed within or without the commonwealth and which covers residents of the commonwealth.

_____

(b) In the event of the remarriage of the group plan member referred to in subsection (a), the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or the issuance of an individual plan, either of which may be at additional premium rates determined by the commissioner of insurance to be just and reasonable in accordance with the additional insuring risks involved."
(See also M.G.L. c. 176A, § 8F; M.G.L. c. 176B §6B; and M.G.L. c. 176G §5A)

_____ **Group Health Care Insurers.** According to 940 CMR 9.04, it shall be considered an unfair and deceptive act or practice in violation of M.G.L. c. 93A, § 2, for a carrier to deny a member's claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the member prior to the date the covered health care services were received in the manner set forth in 940 CMR 9.05.